Appendix 1: Further reading

Following are additional comments regarding the legislative process, the interest groups and their effect on the process, further information on the changes in the mental health service system and initial effects of the rehabilitation reform, as well as remarks on several critical issues and challenges faced by the rehabilitation service system as it enters the second decade of implementing the RMD law.

As in many social changes, leadership has been an important factor in the mental health rehabilitation legislation too. We believe that without the leadership, commitment and determination of Mrs. Tamar Goz'ansky, one of the most respected social legislators of the Israeli Knesset, who initiated and led the legislative process, this law would have not been enacted. However, the efforts of the leadership were allowed to bear fruit (2, 5) thanks to a configuration of factors, including a coalition of interest groups and specific legislative and political circumstances. First, at that time, it was possible for members of the legislature to initiate new legislative proposals without the approval of the executive branch, even if its implementation would have committed the government to great expense. Members of the Knesset (Israel's Parliament) used this option (which has since been made illegal) and submitted the bill. Second, the mental health administration recognized the opportunity, joined the legislators and eventually, was able to shape the law according their ideas. Third, family members and service users seized the opportunity and created a public lobby in support of the bill. Finally, the Ministry of Finance, who initially tried to prevent this legislation out of concern that it would lead to uncontrolled and unpredictable spending, realized that the bill would be passed and decided to support it. This support and the budgeting of this legislation was a critical factor in the implementation of the RMD law. However, this support carried a cost. The Ministry of Finance conditioned its budgeting on an agreement with the Ministry of Health for a massive reduction in the number of psychiatric beds (2, 5).

During the legislative process, psychiatric hospitals were interested to be eligible for rehabilitation funds that would result from this law. However, in lieu with progressive rehabilitation approaches (3, 4, 26), in order to assure that funds would be directed toward provision of psychiatric rehabilitation services in the community and not toward existing rehabilitation units within hospitals, the promoters of the legislation stated clearly in the law that it refers to community-based rehabilitation.

It is not surprising that in addition to the significant decline in the rates of psychiatric beds in the country and the sizeable increase in the number of persons receiving rehabilitation services, there were significant reductions in the length of stay and the number of inpatient days in psychiatric hospitals (2, 6). Figure 2 (in online appendix) shows the interrelationship between the changes occurring in the mental health services (6, 7, 8).

The changes in inpatients services during the last decade resulted in financial savings. Between 1999 and 2009, there were 912,127 fewer inpatient days for the whole decade than if the rate had remained the same as in 1998 (6).Thus, a crude estimate based on the current tariff for the daily cost of inpatients over a decade (at constant prices for 2009) indicated a saving of over NIS 1 billion (approximately $ 275 million) above the total amount spent during this decade on rehabilitation services.

As we have described, initially, during the legislative process the Ministry of Finance concerned with uncontrolled budgetary demands, tried to block the approval of the Bill. However, once realizing the approval had become eminent, the Ministry decided to support the legislation but conditioned the financing of the implementation of the Law by a massive reduction of the number of psychiatric beds in the country. However, this agreement and the actual decline in the number of psychiatric beds did not ease the officials of the Ministry of its concern of losing control over the expenditures due to services demand from entitled persons. As a result, the Ministry of Finance has recently conditioned its support for a major mental health insurance reform (which entails transferring the responsibility for providing mental health inpatient and ambulatory services to the heath care providing organizations), on including "rider" legislation (section 12 in the mental health reform law), and changing the RMD law (10). The Knesset's acceptance of this proposed change would be a major blow to the RMD law.

One of the major issues faced by the rehabilitation service system is the fact that there has been no rapid increase in the number of persons with mental illness receiving services, and based on the estimates of the size of the eligible population the system has not yet covered the majority of the psychiatrically disabled group. This might be due to budget limitations that could allow outreach services, require a larger staff and the reworking of services based on the specific needs of special populations and outlying areas.

One of the most critical challenges of the rehabilitation service system is the development of research and evaluation services. It will have to meet the growing administrative, political and social demands to assess the effectiveness and efficiency of its services. Yet, in responding to this it must overcome the fact that no consensus yet exists about what should be measured and how or even how the data would be used once it is collected,

and about criteria for success. Despite these difficulties, it is important to develop such a system and to adapt a multidimensional approach as well as considering possible social and economic benefits such as free market employment in addition to individual benefits (12).

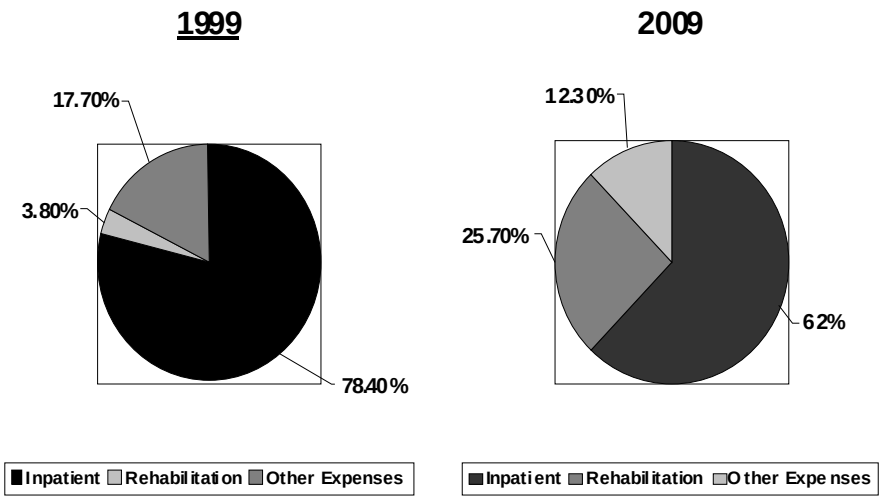
As indicated, the personnel operating the services are an important matter to relate to. It is crucial to develop a clear definition of the roles within the rapidly developing psychiatric rehabilitation field. Also, an agreement about the required knowledge, values and skills to perform these roles is necessary. As is the case in other countries and is argued elsewhere (22), some of the roles in psychiatric rehabilitation require unique, specialized knowledge, skills and values that are not necessarily provided by the traditional professional and academic training programs.

Related to the above mentioned issues is the fact that privatization of the services and money-saving efforts are affecting the quality of the personnel employed by these services. In an effort to save expenses, operators of services have a strong incentive to hire low-level personnel and provide as little training as possible. In its efforts to reduce costs, the government refrains from drawing up tough contracts demanding high-level personnel who receive ongoing training.

Another financial-driven force, which often influences the quality of the program, is that rehabilitation agencies are paid based only on the number of people to whom they provide service with no allowance for innovation and experimentation. Consequently, agencies have an incentive for "creaming," selecting and maintaining easy and stable service users, and even going as far as to discourage people from moving along the continuum of less restrictive or less intensive services.

Appendix 2: Figures

Figure 1: Budget Distribution for Mental Health Services, Israel, 1999-2009*



*Budgets include changes during the year.

Source: State Budget years 1999-2009

Figure 2: Increase in the Number of Persons in Rehabilitation Services in thethe Community and Decline in the Number of Days in Mental Hospitals, Israel, 1999-2009:

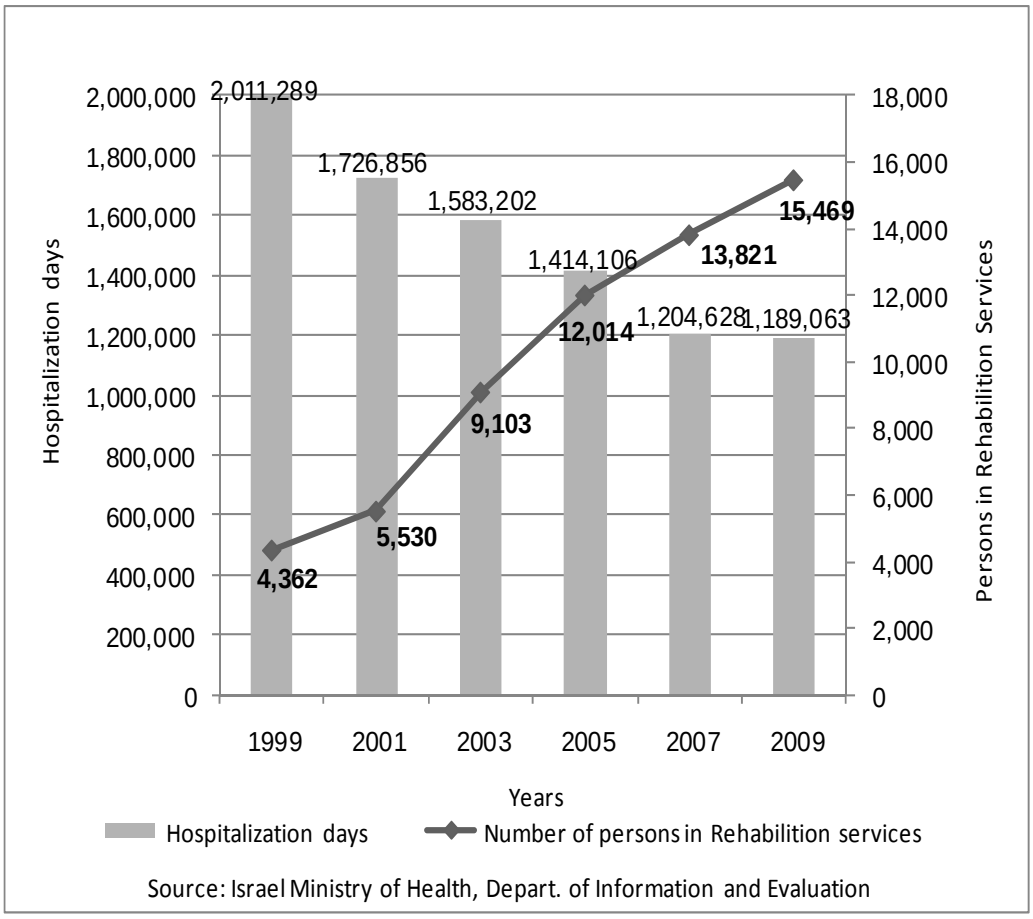
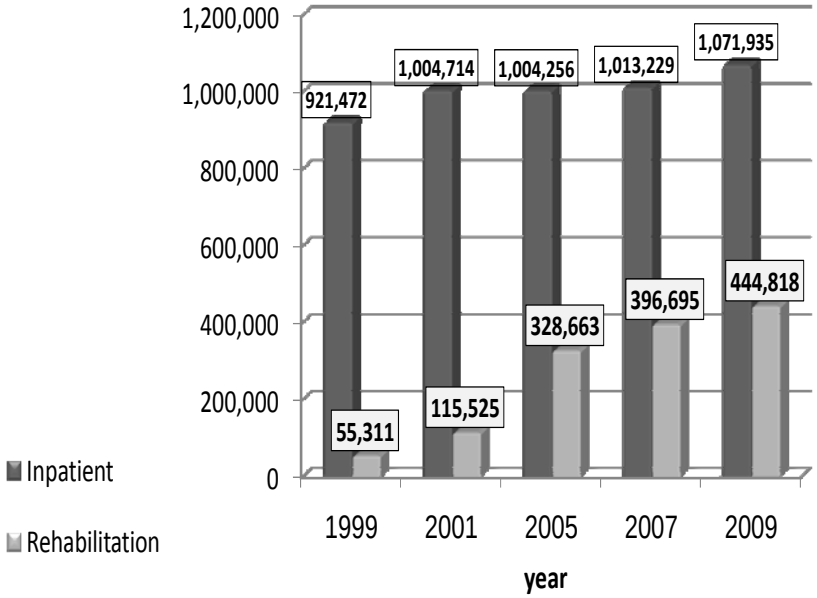


Figure 3: Budget for Mental Health Services: Inpatients* and Rehabilitation in the Community, 1999-2009**



* Inpatients include: psychiatric hospitals, acquisitions from hospitals, and acquisitions of hospitalization substitutes.

** In thousands of NIS, constant prices based on the health index of 2009.

Source: Israel State Budgets, 1999-2009, , and Department for Planning and Budgeting, Ministry of Health .

Appendix 3: Additional references

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(10) Rehabilitation and integration of treated mentally ill in the community. signed by Dr. Boaz Lev, Director General of the Ministry of Health, Prof. Mordechai Shani, Director General of Sheeba Hospital and Yael Andorn-Vermus, Deputy Director of Budgets (by letter from Prof. Shani to Dr Lev, July 11, 2001 (#2014/01) (Mimeo), In Hebrew)

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